EXHIBIT 29

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Description: This SOP outlines the "know your customer" due diligence process for new and existing customers and applies to all customers purchasing schedule II-V controlled substances and List 1 chemicals.

Signatures:
Signed By : Bacco, Danielle (baccod)
Decision : Approved
Decision Date : 14 Aug 2017 11:18:22 GMT -04:00
Role : CMM Peer Review Role
Purpose : New Departmental SOP being loaded into DocCompliance
Meaning Of Signature : CMM_As the Peer Reviewer, I have reviewed this document for accuracy and completeness.

Signed By : Brantley, Eric (branter)
Decision : Approved
Decision Date : 17 Aug 2017 15:51:54 GMT -04:00
Role : CMM Author Role
Purpose : New Departmental SOP being loaded into DocCompliance
Meaning Of Signature : CMM_As the Author, I have written this document and attest to its accuracy and completeness.

Signed By : Stroud, Alexis (stroual)
Decision : Approved
Decision Date : 18 Aug 2017 10:16:12 GMT -04:00
Role : CMM Peer Review Role
Purpose : New Departmental SOP being loaded into DocCompliance
Meaning Of Signature : CMM_As the Peer Reviewer, I have reviewed this document for accuracy and completeness.

Signed By : Feltz, Margaret (feltzm)
Decision : Approved

Decision Date : 22 Sep 2017 15:15:17 GMT -04:00
Role : CMM Dept Approver Role
Purpose : New Departmental SOP being loaded into DocCompliance
Meaning Of Signature : CMM_As the Department Approver, I have reviewed this document for accuracy and completeness.

Owning Departments:
STM Corporate Compliance

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PURDUE PHARMA L.P. and ASSOCIATED US COMPANIES
STANDARD OPERATING PROCEDURE

SOP NUM.: CC-SOP-000018
TITLE: KNOW YOUR CUSTOMER DUE DILIGENCE

1. PURPOSE

This SOP outlines the "know your customer" due diligence process for new and existing customers.

2. SCOPE

This SOP applies to all customers purchasing schedule II-V controlled substances and List 1 chemicals.

3. DEFINITIONS

Diversion	Controlled substance purchase with the intent of illicit use; and/or the sale or distribution of controlled substances into other than legitimate medical, scientific, and industrial channels.
Dosage Unit	A single solid oral dosage form such as a tablet, capsule, or pill. A unit dose contained in a syringe, bottle, or vial. A unit dose contained in a transdermal patch.
SOM	Suspicious Order Monitoring (SOM)- "The registrant shall design and operate a system to disclose to the registrant suspicious orders of controlled substances. The registrant shall inform the Field Division Office of the Administration in his area of the suspicious orders when discovered by the registrant. Suspicious orders include orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency." *21 CFR 1301.74(b)*
Threshold	Monthly maximum quantity in dosage units for each DEA controlled substance base code and/or strength unique to a customer. The monthly Threshold caps the total number of doses that a customer may order for a controlled substance base code in any calendar month.

4. GENERAL

Prior to the initial sale or distribution of controlled substances or List 1 chemicals to a new customer, Ethics & Compliance conducts a thorough review of the customer. If the review concludes that there is an unreasonable risk of Diversion, the customer will be blocked from ordering controlled substances or List 1 chemicals.

5. PROCEDURE

I. Customer Review

A. Customer Service sends the appropriate questionnaire based on class of trade to the potential new customer or existing customer with a new DEA registered location. The completed questionnaires and all supporting documentation are sent to Ethics & Compliance. Any customer questions or concerns should be directed to Ethics & Compliance.

B. Ethics & Compliance reviews the information provided by the customer. The review may include:

i. Internet search on company and owners for disciplinary actions, internet pharmacy affiliations, pending enforcement activities or litigation, etc.

ii. Background checks on owners, principals, Pharmacist in Charge (PIC), or other appropriate employees/associates that may be conducted by Corporate Security at the request of Ethics & Compliance.

iii. Review of customer's SOM summary or SOP to ensure program meets the minimum requirements of 21 CFR 1301.74(b).

iv. Verification that Pharmacist in Charge (PIC) license for mail-order pharmacy is valid and in good standing; and research of any disciplinary actions.

C. If the customer fails to provide a SOP or summary of its SOM program, or if it is found to be deficient in meeting the minimum requirements of 21 CFR 1301.74(b), the customer will be prohibited from ordering controlled substances and List 1 chemicals until a SOP or summary that meets the minimum requirements is provided.

D. If the customer fails to provide the number of customers to which it distributes controlled substances, the customer will be prohibited from ordering controlled substances and List 1 chemicals until the information is provided.

E. If the review concludes that there is an unreasonable risk of Diversion, the customer will be prohibited from ordering controlled substances or List 1 chemicals.

F. Customers must complete an annual review questionnaire at the end of each calendar year. Ethics & Compliance will distribute and collect the questionnaires and vet accordingly. Customer Thresholds will be adjusted in alignment with the information provided.

II. Site Visits

A. Each customer ordering controlled substances from Purdue must have a "know your customer" site visit conducted by a member of Ethics & Compliance, Corporate Security, or a third-party consultant. The purpose of the visit is to assess the effectiveness of the customer's SOM program, corroborate with SOP/summary, observe a demonstration of software (if applicable), and discuss the Purdue SOM program and answer any questions.

B. New customers should be visited within the first six (6) months of opening an account. If there are concerns or questions regarding the customer's SOM program or other information provided on the questionnaire, a site visit must be conducted prior to allowing the customer to order controlled substances or List 1 chemicals.

C. A site visit report will be prepared and saved in the customer's file. If the customer's SOM program is found to be inconsistent with SOP and fails to meet the minimum requirements of 21 CFR 1301.74(b), a determination will be made on remedial action up to and including precluding customer from ordering controlled substances.

D. "Know your customer" site visits will be a one-time occurrence unless a subsequent due diligence visit becomes necessary to address SOM compliance concerns, or a substantial change in the customer's business model or SOM program.

III. Customer Thresholds

A. Customer Thresholds for drug families and/or strengths will be based in part on the information provided by the customer. The types and number of customers receiving controlled substances will be used with national dispensing averages obtained from a third-party to determine Thresholds.

B. Thresholds will be routinely adjusted at least annually based on updated national dispensing data, and customer information provided on annual review questionnaire. If the customer alerts Ethics & Compliance of increases or decreases in the number of customers served (e.g. new or lost business) at any time throughout the year, the Thresholds will be adjusted accordingly.

6. REFERENCES

N/A

7. CHANGE HISTORY

Version	Section	Change
N/A	N/A	N/A – New SOP

8. ATTACHMENTS

Attachment A - Wholesaler/Distributor Questionnaire (Page 1)

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

WHOLESALER/ DISTRIBUTOR QUESTIONNAIRE

CORPORATE INFORMATION

1. Company Name _____
2. Address _____
   City_____ State_____ Zip _____
3. Corporation_____ Limited Partnership_____ Sole Proprietor_____ Other_____
4. Wholly owned by/Subsidiary of *(If Applicable)* _____
5. Owner(s) Name *(If Corporation please provide list of Officers)* _____
   _____
   _____
6. Has Owner/Officer ever been convicted of a crime related to the distribution of pharmaceuticals including controlled substances and List 1 Chemicals? _____
   i. If yes, please provide details in separate attachment.

DISTRIBUTION CENTER INFORMATION

7. Name as it appears on DEA Registration _____
8. Address _____
   City _____ State _____ Zip _____
9. DEA Registration # _____ (please attach copy)
10. State of domicile License # _____ (please attach copy)
11. State Controlled Substance License # _____ (please attach copy)
12. Is facility VAWD certified? _____ (please attach copy)
13. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act (CSA), specifically 21 U.S.C 823(b)(1); 21 U.S.C 823(e)(1); 21 U.S.C 842(a)(5) and/or 21 CFR 1301.74(b) relating to the distribution and/or Suspicious Order Monitoring of controlled substances? _____
    i. If yes, please provide details in separate attachment

14. Does Company have a Suspicious Order Monitoring program in compliance with 21 CFR 1301.74(b)? _____ *(Please attach SOP or summary of program)*

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Attachment A - Wholesaler/Distributor Questionnaire (Page 2)

Purdue Pharma L.P.

15. Please provide a general description of business

_____

_____

_____

16. Please provide the number of customers the facility distributes controlled substances for each customer type.

Retail Independent Pharmacies _____ Hospitals _____
Retail Chain Pharmacies _____ Closed Door Pharmacies _____
Mail Order Pharmacies _____ Physician Offices _____
Wholesalers _____ Government/DOD _____
Veterinary Offices _____ Pain Clinics _____
Other _____ # _____

17. Is facility generally the primary or secondary supplier to customers? _____

18. Please provide information for SOM program point of contact.
Name _____ Phone# _____
Email _____

19. Please provide contact information for held orders requiring additional information.
Name _____ Phone# _____
Email _____

MULTIPLE DISTRIBUTION CENTERS

If company has multiple DEA registered Distribution Centers receiving controlled substances, please complete a questionnaire for each facility. A single questionnaire along with a spread sheet with license information and the number and types of customers can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include copies of licenses and attachments explaining disciplinary actions with spreadsheet.

Name _____ Date _____

Attachment B - Retail Chain Pharmacy Questionnaire (Page 1)

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

CHAIN PHARMACY QUESTIONNAIRE

CORPORATE INFORMATION

1. Company Name _____
2. Address _____
   City _____ State _____ Zip _____
3. Corporation____ Limited Partnership____ Sole Proprietor_____ Other_____
4. Wholly owned by/Subsidiary of *(If Applicable)* _____
5. Owner(s) Name *(If Corporation please provide list of Officers)* _____
   _____
   _____
6. Has Owner/Officer ever been convicted of a crime related to the distribution of pharmaceuticals including controlled substances and List 1 Chemicals? _____
   i. If yes, please provide details in separate attachment

DISTRIBUTION CENTER INFORMATION

7. Name as it appears on DEA Registration _____
8. Address _____
   City _____ State _____ Zip _____
9. DEA Registration # _____ (please attach copy)
10. State of domicile License # _____ (please attach copy)
11. State Controlled Substance License # _____ (please attach copy)
12. Is facility VAWD certified? _____ (please attach copy)
13. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act (CSA), specifically 21 U.S.C 823(b)(1); 21 U.S.C 823(e)(1); 21 U.S.C 842(a)(5) and/or 21 CFR 1301.74(b) relating to the distribution and/or Suspicious Order Monitoring of controlled substances? _____
    i. If yes, please provide details in separate attachment

14. Does Company have a Suspicious Order Monitoring program in compliance with 21 CFR 1301.74(b)? _____ *(Please attach SOP or summary of program)*

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Attachment B - Retail Chain Pharmacy Questionnaire (Page 2)

15. Please provide a general description of business

_____

16. Does this facility distribute controlled substances to pharmacies other than company owned pharmacies? _____
    i. If yes, please provide name(s) of pharmacies _____
    _____
    ii. If yes, which entity manages Suspicious Order Monitoring? _____
    _____

17. Please provide the number of pharmacies the facility distributes controlled substances.

    Company Owned Retail Pharmacies _____
    Non Company Owned Retail Pharmacies _____
    Closed Door Pharmacies _____
    Other _____ # _____
    Other _____ # _____

18. Please provide information for SOM program point of contact.
    Name _____ Phone# _____
    Email _____
    Please provide contact information for held orders requiring additional information.
    Name _____ Phone# _____
    Email _____

MULTIPLE DISTRIBUTION CENTERS/PHARMACIES

If company has multiple DEA registered Distribution Centers receiving controlled substances, please complete a questionnaire for each facility. A single questionnaire along with a spread sheet with license information and the number and types of customers can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include copies of licenses and attachments explaining disciplinary actions with spreadsheet.

Name _____ Date _____

Attachment C – Mail Order Questionnaire (Page 1)

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

MAIL ORDER QUESTIONNAIRE

CORPORATE INFORMATION

1. Company Name _____
2. Address _____
   City _____ State _____ Zip _____
3. Corporation_____ Limited Partnership_____ Sole Proprietor_____ Other_____
4. Wholly owned by/Subsidiary of (*If Applicable*) _____
5. Owner(s) Name *(If Corporation please provide list of Officers)* _____
   _____
   _____
6. Has Owner/Officer ever been convicted of a crime related to the distribution of pharmaceuticals including controlled substances and List 1 Chemicals? _____
   i. If yes, please provide details in separate attachment.

DISTRIBUTION CENTER / PHARMACY INFORMATION

7. Name as it appears on DEA Registration _____
8. Address _____
   City _____ State _____ Zip _____
9. DEA Registration # _____ (please attach copy)
10. State of domicile License # _____ (please attach copy)
11. State Controlled Substance License # _____ (please attach copy)
12. Is facility VAWD certified? _____ (please attach copy)
13. Name of Pharmacist in Charge _____
14. PIC DEA Registration # _____
15. PIC State License # _____
16. Is Pharmacy VIPPS certified? _____
17. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act, 21 CFR 1301.74(b), and/or 21 CFR 1306.04(a) relating to the pharmacists' corresponding responsibility for the proper dispensing of controlled substances? _____
    i. If yes, please provide details in separate attachment

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Attachment C – Mail Order Questionnaire (Page 2)

Purdue Pharma L.P.

18. Does Company have a Suspicious Order Monitoring program in compliance with 21 CFR 1301.74(b)? _____ *(Please attach SOP or summary of program)*

19. Does Pharmacist fulfill his/her corresponding responsibility under 21 CFR 1306.04 for the proper dispensing of controlled substances for a legitimate medical purpose? _____ *(Please attach SOP or program summary)*

20. Please provide the average number of prescriptions filled monthly _____
    i. What percentage are for controlled substances? _____

21. Please provide information for SOM program point of contact.
    Name _____ Phone# _____
    Email _____
22. Please provide contact information for held orders requiring additional information.
    Name _____ Phone# _____
    Email _____

MULTIPLE FACILITIES

If company has multiple DEA registered Distribution Centers/pharmacies receiving controlled substances, please complete a questionnaire for each facility. A single questionnaire along with a spread sheet with license information and the average number of prescriptions filled monthly for each location can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include copies of licenses and attachments explaining disciplinary actions with spreadsheet.

Name _____ Date _____

PURDUE PHARMA L.P. and ASSOCIATED US COMPANIES
STANDARD OPERATING PROCEDURE

SOP NUM.: CC-SOP-000018
TITLE: KNOW YOUR CUSTOMER DUE DILIGENCE

Attachment D - Wholesaler/Distributor Annual Review

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

WHOLESALER/ DISTRIBUTOR ANNUAL REVIEW

1. Name as it appears on DEA Registration _____
2. Address _____
   City _____ State _____ Zip _____
3. Has there been a change in ownership? _____
   i. If yes, please provide information _____
4. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act and/or 21 CFR 1301.74(b) relating to the distribution and/or Suspicious Order Monitoring of controlled substances? _____
   i. If yes, please provide details in separate attachment
5. Please provide the number of customers the facility distributes controlled substances
   Retail Independent Pharmacies _____ Hospitals _____
   Retail Chain Pharmacies _____ Closed Door Pharmacies _____
   Mail Order Pharmacies _____ Physician Offices _____
   Wholesalers _____ Government/DOD _____
   Veterinary Offices _____ Pain Clinics _____
   Other _____ # _____
6. Please provide information for SOM program point of contact.
   Name _____ Phone= _____
   Email _____
7. Please provide contact information for held orders requiring additional information.
   Name _____ Phone= _____
   Email _____

If company has multiple DEA registered Distribution Centers receiving controlled substances, please complete an annual review for each facility. A single questionnaire along with a spread sheet with the number and types of customers can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include attachments explaining disciplinary actions with spreadsheet.

Name _____ Date _____

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Attachment E - Retail Chain Annual Review

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

CHAIN PHARMACY ANNUAL REVIEW

1. Name as it appears on DEA Registration _____
2. Address _____
   City _____ State _____ Zip _____
3. Has there been a change in ownership? _____
4. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act and/or 21 CFR 1301.74(b) relating to the distribution and/or Suspicious Order Monitoring of controlled substances? _____
   i. If yes, please provide details in separate attachment
5. Does this facility distribute controlled substances to pharmacies other than company owned pharmacies? _____
   i. If yes, please provide name(s) of pharmacies _____
   _____
6. Please provide the number of pharmacies the facility distributes controlled substances.
   Company Owned Retail Pharmacies _____
   Non Company Owned Retail Pharmacies _____
   Closed Door Pharmacies _____
   Other _____ # _____
7. Please provide information for SOM program point of contact.
   Name _____ Phone# _____
   Email _____
   Please provide contact information for held orders requiring additional information.
   Name _____ Phone# _____
   Email _____

If company has multiple DEA registered Distribution Centers receiving controlled substances, please complete an annual review for each facility. A single questionnaire along with a spread sheet with the number and types of customers can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include attachments explaining disciplinary actions with spreadsheet

Name _____ Date _____

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Attachment F – Mail Order Annual Review

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

MAIL ORDER ANNUAL REVIEW

1. Name as it appears on DEA Registration _____
2. Address _____
   City _____ State _____ Zip _____
3. Has there been a change in ownership? _____
4. Name of Pharmacist in Charge _____
5. PIC DEA Registration # _____
6. PIC State License # _____
7. Have there been any disciplinary actions for alleged violations of The Controlled Substance Act, 21 CFR 1301.74(b), and/or 21 CFR 1306.04(a) relating to the pharmacists' corresponding responsibility for the proper dispensing of controlled substances? _____
   i. If yes, please provide details in separate attachment
8. Please provide the average number of prescriptions filled monthly _____
   i. What percentage are for controlled substances? _____
9. Please provide information for SOM program point of contact.
   Name _____ Phone# _____
   Email _____
10. Please provide contact information for held orders requiring additional information.
    Name _____ Phone# _____
    Email _____

If company has multiple DEA registered Distribution Centers/pharmacies receiving controlled substances, please complete an annual review for each facility. A single questionnaire along with a spread sheet with the average number of prescriptions filled monthly for each location can be provided in lieu of multiple questionnaires if there are more than five facilities. Please include attachments explaining disciplinary actions with spreadsheet.

Name _____ Date _____

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